DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
445496 Y1	A. Building B. Wing Y2	3/3/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE MEADOWS	8044 COLEY DAVIS ROAD NASHVILLE, TN 37221

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 02/06/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) lm	DATE	SIGNATURE OF SURVEYOR [illegible signature] [illegible signature]	DATE 3/3/2021
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE [illegible] [illegible]	DATE 3/3/2021
FOLLOWUP TO SURVEY COMPLETED ON 1/14/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445496	A. BUILDING _____ B. WING _____	C 01/14/2021

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F 000	INITIAL COMMENTS Complaint investigation #52657 and #52932 was completed on 1/14/2021 at The Meadows. No Deficiencies were cited related to complaint investigation #52657 and 52932, deficiencies were cited for an unrelated infection control issue, under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000	The statements made in the following Plan of Correction are not admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following Plan of Correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in The Plan of Correction. The following Plan of Correction constitutes the centers allegation of compliance. The alleged deficiency cited has been or will be corrected by the date indicated.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880	1.Corrective action for the resident affected by the alleged deficient practice: Facility CNA #2 was inserviced by the DON on 1/14/2021 regarding the proper use of PPE on the COVID 19 unit before survey was completed. No other staff member was identified as not utilizing proper PPE. All staff working the COVID 19 unit were inserviced on 1/14/2021 and 1/15/2021. Monitoring continued for patients (3) on the CoVID 19 unit with no adverse affects noted. The COVID 19 unit closed on 1/18/2021 due to all patients being recovered. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: Further education is being provided for all staff regarding PPE use. This education includes an inservice on PPE, a cue card for donning and doffing, and the CDC video " Prevention Messages for Front Line LTC staff: PPE Lessons." All education will be completed by 2/6/2021 by the Infection Preventionalist/ DON/ Designee. 3. Measures/ Systemic changes put in place to assure deficient practice does not re occur: Moving forward; if there is another COVID 19 outbreak which dictates the creation of a COVID 19 unit, all staff on the unit will be reeducated on the proper use of PPE on the unit by DON/IP/Designee. In addition, all new hire staff and agency staff shall be educated on proper PPE use and watch video from the CDC entitled " Prevention Messages for Frontline LTC Staff: PPE Lessons, prior to taking assignment on the COVID 19 unit. Policy drafted 2/1/2021.	2/18/2021

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BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 2/4/21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 880	Continued From page 1 possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on facility policy review, observations and	F 880	4. Corrective actions will be monitored to ensure the alledged deficient practice will not reoccur: Proper PPE useage will be monitored 3 times a day for a minimum of 4 weeks by unit managers/ IP/ DON/ Designee. DON will analyze and report data to monthly QA committee on 2/18/2021. QA committee will determine whether substantial compliance dictates additional monitoring and will be reviewed at subsequent QA meetings as needed.	2/18/2021

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F 880	Continued From page 2	F 880		

interview the facility failed to follow transmission based precautions for 1 resident of 3 residents observed on the COVID unit.

The findings include:

Review of the facility policy dated 12/98 "Infection Control Manual" showed "The infection Prevention and Control Program is comprehensive in that it addresses detection, control and prevention of infections among patients and partner...The Infection Control Committee will meet at least quarterly, or more if needed , to ensure a safe, sanitary and comfortable environment which will help prevent the development and transmission of disease and infections..."

Review of the facility Memorandum regarding Emerging Infectious Disease Response-Emergency Procedures Plan Manual, dated 3/4/2020 showed "...Healthcare must always be prepared to protect people within our buildings and residents, families, and staff from harm resulting from exposure to an emerging infectious disease while they are in the facility..." Contact precautions are used for residents with known or suspected epidemiologically important infections or colonization with resistant organisms transmitted by direct or indirect contact with residents or environment. Gloves and gowns must be worn when caring for a resident. Discard PPE before leaving the room. Hand hygiene is a critical step after care is completed...Droplet precautions prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. Standard precautions apply. Healthcare workers should wear a mask when entering the room and

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F 880	Continued From page 3	F 880		

if coming into close contact with the resident who is infectious. Hand hygiene is required after completing care..." Continued review showed "...Dining Services as necessary, ensure staff utilize necessary PPE if delivering meals or interacting with residents who may be infectious..."

Review of the undated facility documentation "Guidance for Meal Delivery to COVID unit" showed "...All meals served on disposable ware for in-room dining. Trays for the COVID unit are sent on a separate cart. Dietary delivers the cart to the COVID barrier. Nursing staff removes all trays from the cart and places them on a speed rack that is kept on the COVID unit. This rack never leaves the unit. After the meal, all disposable is placed in the trash on the unit which goes to the designated COVID trash..."

Observation on 1/14/2021 at 11:57 PM showed a tray delivered to the COVID unit on a regular plastic tray, dietary staff was wearing an N95 mask and face shield. Continued observation showed the plastic tray was put on the speedcart on the COVID unit. Further observation showed CNA (certified nursing assistant) #2 wearing only a face shield and N95 mask but not a gown or gloves. Continued observation showed the Styrofoam tray items items were removed from the plastic tray and taken into the resident's room. Further observation showed CNA #2 removed the drinks from the plastic tray and re-entered the resident's room with a face shield and N95 mask but no gown and gloves were used.

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F 880	Continued From page 4 During an interview on 1/14/2021 at 12:19 PM, CNA #2 confirmed she did not don gown when entering COVID resident's room with a food tray. During continued interview she stated she got sidetracked and did not gown up before delivering the tray. During further interview she stated the proper procedure was to wear gown, N95 mask and face shield before entering a patient's room on the COVID unit. During continued interview CNA #2 stated she has just been off with COVID and this was her first day back. During an interview on 1/14/2021 at 12:28 PM, on the corridor to the A hallway with the Infection Control Nurse she confirmed staff on the COVID unit are required to wear a gown, N95 mask, face shield and gloves before entering a resident's room, no exceptions. During an interview on 1/14/2021 at 5:00 PM with the DON she stated on the COVID unit staff can wear the same gown in each room or a patient specific gown. During continued interview she confirmed all staff must wear gowns and gloves in patient rooms on the COVID unit.	F 880		